BULLETIN

SOUTH INDIAN MEDICAL ASSOCIATION.

FEBRUARY 1933.

The Tonsil Problem.*

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The Tonsil Problem is important in as much as it concerns general medicine to a considerable extent. To understand this problem it is first essential to know something about the physiological function of the Tonsils and also the relation of Tonsillar infections to general affections. From the beginning it must be stated that we do not up to now clearly understand the function of the Tonsils. It was towards the end of last century that the theory of focal infection from Tonsils came into vogue and it became the fashion to remove almost every child's Tonsils. Later there came a set back, from the theory of protective function of the Tonsils advocated by Brieger. This was again reversed by Paessler who brought forward the theory of infection of the Tonsillar crypts. Now the Tonsils are a part of the lymphatic system and naturally along with the rest of the lymphatic system lymphocytes are produced in them. In addition to this the Tonsils may also be considered as reaction centres against invading Toxins. It is really an admitted fact that healthy Tonsils during childhood are protective organs which keep the body ready for defence against invading organisms and toxins. But then it must be clearly understood that the Tonsils only take up a very small part of this defence when compared to the rest of the lymphatic system. Certain research workers have also advanced a theory that Tonsils are concerned with digestion. Another theory is that the Tonsils are endocrine glands. But this has been finally repudiated. There is yet again another view that Tonsils are concerned with growth This was started from the observation that children very often thrive after the removal of Tonsils Voss of Russia fed Tadpoles on Tonsillar substance and found they were behind hand in growth compared to control animals. This too is not conclusively proved as other workers have reported to the contrary. So we see that after all we really know very little about the function of the Tonsils. But the fact that the Tonsils form a very small part of the lymphadenoid tissue of the oral cavity and pharynx and that by removing the Tonsils we remove only a very small part of this system easily proves that the removal of Tonsils can do no harm. This is abundantly proved by clinical experience all over the world. You never come across any bad effects after proper removal of the Tonsils. There is again another important thing to be noted. After removal of Tonsils there is no compensatory hypertrophy of the remaining lymphadenoid tissue of the oral cavity which would naturally take place if the Tonsils had some important function to perform. I must here mention another important characteristic of the Tonsils. The Tonsils have crypts. There are crypts also in the rest of the oral lymphoid tissue but they are washed out by the mucus, being much shallower. This does not take place with the Tonsils and that is why the crypts become so easily septic. Now this leads us on to the question of focal infection from Tonsils. Paessler suggests that more than 45 diseases could be traced to the Tonsils, as the source of infection. This is rather far fetched. But it is now generally recognised that Rheumatic Disease Endocarditis, Septic Diseases and Nephritis are very often connected with the Tonsils. Formerly it was thought that enlarged Tonsils were responsible for this but now we know that it is not the enlarged Tonsils but the small ones with deep crypts and plugs that are more responsible and that should

* University Extension lectures,

be removed. This leads us on to the question of the plugs in the Tonsils and whether they are the source of infection. Here again there were two opposing views. One was that the plugs in the crypts were the true source of infection and the other that they are perfectly harmless. But now we know for certain that infected Tonsils do cause general illness and that removal of Tonsils cures these diseases and the patients thereafter continue to remain in good health. Then how are we to determine whether a Tonsil is unhealthy or not? Formerly enlargement, appearance of the crypts and the formation of plugs in the Tonsils were the main symptoms of chronic Tonsillitis. This is not absolutely correct because there is very often a physiological hypertrophy and the Tonsils through repeated attacks of inflammation also cause it. The appearance of the crypts also is misleading because crypts are present in all Tonsils. But we can say whether a Tonsil is septic or not from the kind of plugs in the crypts. The hard concretions forming part of keratosis phanyngis is not of much importance nor are calcareous crumbling plugs of much importance. But if we can squeeze pus out of the Tonsils or if the plugs on microscopic examination contain a great number of leucocytes then we can say that those Tonsils should be removed. Then again there are the Tonsils with blocked crypts and infection inside. How is one to detect this without removal; so we can say that if there are repeated attacks of inflammation or quinsies or if there is a general disease traceable to a focal infection and where only the Tonsil is suspeced then it should invariably be removed —we can modify this a bit further and say that the indications for removal of Tonsils are in addition the following

(1) For enlarged cervical glands especially if of Tuberculous nature.

(2) For middle ear disease when enlarged Tonsils are present.

(3) For mouth breathing due to enlarged Tonsils.

(4) Recurrent general "Sore throat" where no special cause can be found.

(5) Impaired nutrition.

(6) Nasal voice and defective articulation.

(7) Benign and malignant growths.

(8) Diptheria carriers.

How are these Tonsils then to be removed. Total removal of the Tonsils is a very ancient operation. Hippocrates in 460 B.C. advised removal of the Tonsils. Celsus in A.D. 10, described the operation as follows: "Tonsils which remain indurated after inflammation, if covered by a thin membrane, should be loosened by working the finger round them and then torn out. But when this is not practicable they should be seized by a hook and excised with a scalpel". Apparently during this time and for sometime later there was no fear of haemorrhage: then there came a set back due mainly to fear of haemorrhage till about 1757 when Caque started removing Tonsils at Rheims. Improvement in instruments also began to follow.. But the customary operation was to cut off the portion that projected beyond the pillars. It was in 1827 that the first Tonsillotome or Guillotine was designed by Physick of Philadelphia. Here again it must be remembered it was only partial removal or Tonsillotomy that was practised. This went on till 1861 when Borelli of Italy again started removing Tonsils with the fingers and said that there was no risk of haemorrhage. But this went out of vogue and Guillotine removal became the fashion when in 1899 it practically was abandoned in America for the ennucleation method of Ballenger. In 1908 this method of dissection—blunt dissection—was start-

ed in England by George Waugh. In 1911 Whillis and Pypus introduced the Reverse Guillotine method. This resuscitated the use Guillotine in America and England. There are certain contra-indications to operations which are the following

(1) When there is acute inflammation of the Tonsils as then there is a great tendency to haemorrhage. We must wait at least three weeks after the inflammation has subsided.

(2) *Heart disease.* Here again the danger is supposed to be haemorrhage. But several cases have been done without any risk.

(3) Secondary anaemias.

(4) Lymphadenoma.

(5) Haemophilia.

(6) Arterio-sclerosis.

(7) Menstruation. The best time is midway between the periods.

(8) Finally, Tonsillectomy should not be done too soon after an acute purulent otitis media,

Preparation of the Patient for operation.—There is no special prepation necessary. A purgative may or may not be given beforehand. Administration of calcium Lactate in 20 gr. doses three times on the day before operation controls the haemorrhage to a great extent. No food should be given for four hours before operation and before this only light food should be taken for a day before operation. 1/100 gr. atropine should be given ½ an hour before operation.

Operation.—There are some minor surgical procedures which fall short of the complete removal of the Tonsils. Hence they have nothing to recommend them except that they may be resorted to for some special reason especially where more radical surgery is contra-indicated. The methods are (1) the use of the galvano-cautery to destroy the crypts, (2) crypt knives to enlarge the crypts, (3) crypt forceps to destroy the crypts and (4) punch forceps with which portions of the Tonsil are removed.

The real operation is the complete removal of the Tonsils which may be done either with the guillotine or by dissection.

Anaesthesia.—The operation may be done either with a local anaesthetic or under general anaesthesia.

Local Anaestheria.—Operation under local anaesthesia is usually done on adults who have an equable temperament. It is important to gain the confidence of the patient first. Half an hour before operation a hypodermic injection of ¼ gr. morphia and 1/100 gr. atropine is given. Swabbing the Tonsils with cocaine has nothing to recommend it. The common anaesthetic used is 2 per cent Novocaine with some Adrenalin (5 per cent) in it. Planocaine 1 per cent on Pantocaine 1 in. 1000 are equally effective. With the aid of a special syringe the anaesthetic is injected deeply into the upper pole first and then into the lower pole and then along the anterior and posterior pillars. The same method of anaesthesia is done for the second Tonsil. By the time the second set of injections is finished the first Tonsil will be ready for removal.

There are certain objection to local anaesthesia. They are (1) It is a great strain both for the operator and the patient, (2) Risk of haemorrhage is greater here and more difficult to tackle, (3) Danger of introducing sepsis into the tissues. The last shows how greatly necessary it is to be very careful about proper sterilization of all instruments, especially needles and the anaesthetic.

General anaesthesia.—Here the choice of the anaesthetic depends on whether the operation is to be performed rapidly with the guillotine or

deliberately and slowly by dissection. For the rapid operation Nitrous Oxide or Ethylchloride may be used. For longer anaesthesia a mixture of choloroform and ether is quite satisfactory.

For dissection under a local anaesthetic the patient is seated on a chair and the Surgeon sits in front.

For the guillotine operation or dissection under a general anaesthetic the patient is kept in the recumbent—extended head position, here the shoulders are kept raised with a sand-bag and the head hangs a bit and rests on the vertex.

I do not propose to describe in detail the two methods of operation but must state that I have found ennucleation by dissection very satisfactory. It is the method of choice especially in adults and where the Tonsils are fibrosed. Guillotine is safe in experienced hands and that particularly in the case of children.

There are certain complications which may take place after removal of Tonsils.

I. *Sepsis.* Certain amount of sepsis is sure to take place, with a slight rise of temperature. If it happens to be a bit more one or two intramuscular injection of collosol silver cures it.

II. Sepsis of the Deep Fascia of the neck.

III. Hyperpyrexia. This is extremely rare.

IV. Lung Abscess. This again is a very rare complication.

Lastly we come to haemorrhage after removal of Tonsils. That this is a serious complication is shown from the fact that considerable number of articles have been written on this subject and the number of instruments devised to stop bleeding is numerous. One cannot sufficiently emphasise the importance of sending the patient back from the Theatre only after seeing that all bleeding has completely stopped Fortunately this complication is a rare one. This haemorrhage may be primary, reactionary or secondary. Primary is the commonest and occur during operation. This can usually be stopped by gauze pressure or with gauze soaked in H_2O_2 or turpentine. Also washing the face and neck with ice cold water or applying ice to neck. But this is not of much use in excessive haemorrhage. A deliberate search should be made for the bleeding points and if found these points should be ligatured for which there are special instruments devised. If these points cannot be caught or if there is general oozing the two pillars should be tied together either simply or with a pad of gauze between them. The stitches and pad should be removed the next day.

Reactionary haemorrhage usually takes place within about 3-6 hours after operation. Invariably it is a general oozing. Here again the method of arrest is as in the former. You usually find a clot of blood in the Tonsillar fossa. This should be first removed.

Secondary haemorrhage usually takes place with the separation of the slough and should be dealt with as in primary or reactionary haemorrhage. Sometimes and this is exceedingly rare it may be necessary to leave a clamp with one blade in the Tonsillar fossa and another on the neck giving counter pressure.

Before I conclude I would like to mention one method of removal of Tonsils without operation, *i.e.*, with London paste. This certainly is not as effective as operation but is indicated in cases unfit for operative removal. London paste is made up of equal quantities of caustic Soda and unslaked lime. This is made into a paste with absolute alcohol. The Tonsil surface is first anaesthetised with cocain and the paste applied to the Tonsil with special applicators for 3—5 seconds. The application may be repeated every week. This destroys

the Tonsillar tissue in layers. The number of applications depends mostly upon the size of the Tonsils ; when applying the paste one must be careful to avoid the pillars and other normal tissues. The special applicators obviate this.

Lastly after removal of Tonsils careful after treatment is necessary. Patients should be confined to bed for the first three days after operation and should be allowed to go out of doors or travel only after 10 days from the day of operation. If there is pain ice should be applied to the neck on the first day and hot fomentations on succeeding days. Throat should be touched with H_2O_2 on the first two or three days. An antiseptic gargle should be used several times for the first few days. Food should be light and nourishing.

Acne Vulgaris.

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Acne Vulgaris is a very common condition and one which worries the patient very much owing to the effect of the infection on the cosmetic field.

Cause.—It is the result of infection by a micro-organism—the micro-bacillus of Unna. This bacillus is very difficult to grow in culture. They are small, punctate and look like cocci. When further grown, they are long, and grouped in clusters and are often mistaken for Tubercle Bacilli.

It is basophilic, look fatter when stained by some stains, and thinner when by others, due to the outer coat not taking stain with the latter dyes. Staphylococcus of a weak type is also found in all cases.

Distribution.—Face, forehead, front of chest, back of chest, nape of neck, and the deltoid region are the most favoured regions. The following clinical varieties are seen :

(*a*) Black little dots—*A. punctata.*

(*b*) Inflammed base shown as papule —*A. Papullata.*

(*c*) Indurated—*A. Indurata.*

(*d*) Suppurating—*A. Suppurata.*

It is most commonly seen at the age of puberty. The following have been considered as predisposing factors :

1. Increased metabolic activity of the pilo-sebaceous apparatus at puberty.

2. Some disorders connected with genital organs.

3. Gastro-intestinal disorders, especially gastro-intestinal fermentation and putrefaction.

At the age of puberty 90 per cent. of individuals show presence of gastro-intestinal putrefaction as demonstrated by the presence of indican, phenol or cresol in urine. These signs of gastro-intestinal putrefaction have a tendency to be cleared after adolescence.

Septic foci, which have not entirely been cured, flare up with any occasion where there is intestinal putrefaction, menstrual troubles, in later ages dysmenorrhœa, or when any other endocrine derangement manifests itself.

Course.—Acne vulgaris shows itself in two stages of life :—(i) At the age of puberty. (ii) In old age (in second childhood).

There is seen an increased metabolic activity of the whole system as shown by development of hair where there were only lanugo hairs. Increased action of pilo-sebaceous apparatus produces hyperæmia and increased activity of the sebaceous glands which is first seen in production of large quantity of fatty material inside the glands. This stage is known as *seborrhœac stage.* Sometimes these dry up and become associated with hyperkeratosis. Then one sees a thin scaly material generally found at the angle of the nose, and post-auricular

surface. So far there is no obstruction to sebum extrusion. Sebum is extruded, but when hyperkeratosis takes place a plug is formed which prevents the sebum from extrusion. This plug gets oxidized, becomes black and results in a *comedone.*

Microscopic appearance of Sebum :—Plenty of Acne Bacilli are found. Staphylococci are present in a large number of cases. Whether the inflammation is caused by the Acne Bacillus or is a secondary infection by staphylococcus is an open question. In an equal number of cases pus has been found. Without staphylococcus inflammation there can be no pus. These staphylococci are probably of low vitality, and become autolysed. As such the pus is sterile. Pus in these cases show large number of polymorphonuclear leucocytes, macrocytes and large number of giant cells.

After this, the base shows signs of inflammation. It is raised above the level of the skin and shows as a *papule.*

When inflammation is established and abscess formation takes place, they become pustular in character. The apex atrophies, pus discharges itself and when discharged takes away the loose plug which has already been noticed as the black spot in the comedone.

Sometimes two or three comedones show necrosis laterally, communicate with each other, and open out in two or three orifices with intercommunicating channels leaving behind on healing a hand-like scar.

Signs and symptoms.—Complexion becomes pale, skin is rough and shows a coarse surface, constipation is invariably present; dyspepsia and anæmia are often accompanying features. In girls menstrual irregularities may be seen.

Diagnosis. Drug eruptions caused by iodides and bromides,—patent blood purifiers contain iodides as main constituent—and syphilides commonly simulate the papular or pustular form.

History of administration of iodides or patent medicines, stigmata of syphilis elsewhere are helpful guides for differential diagnosis.

Treatment.—Attention to general health is important. Correct the constipation. Remove intestinal putrefaction by antiseptics. Restrict diet as far as fermentable materials are concerned. Immoderate ingestion of carbohydrates especially as sweets must be disallowed. The skin is to be kept healthy by massages and baths. Do not use vanishing creams or cold creams. A good soap, plenty of tepid water and a moderately coarse towel form the most serviceable equipment in the treatment of Acne. Gentle friction helps in clearing the pores and removal of the blackhead. The soap should be super-fatted and should not contain excess of alkali. Cheap coloured soaps often aggravate the condition.

Comedones are expressed if necessary by removers. After removal an astringent emollient preparation is to be used.

Pustules.—Nip and express the contents. Wash the part affected with weak antiseptic solution.

Thyroid extract has been found beneficial in some cases

PREPARATIONS THAT MAY BE USED.

Seborrhœac stage.

Liq. ammon fortis m. 30.
Ether puris m. 60.
Sapo mollis oz. 1.

mix.

Wash well with hot water after gently dabbing the affected area.

Hyperkeratosis.

Salicylic acid.
Acetic acid.
Hydrogen peroxide. } a a dr. 1
Vaseline.
Anhyd. lanoline.
Vanilla essence—q.s.

Care should be taken to prevent the medicine having access to the eyes. Bandaging the eyes during the application is a safe course.

Comedone.

Pot. Sulphurate.
Zinc Sulphate. } a a ℥i.
Glycerine.

Aqua Rosae i ℥v.

Dab the face with this lotion.

Internally.

Arsenic and yeast may be given.

Reminiscences of Osler in the Early Baltimore Days.*

To have been a disciple and assistant of William Osler for fifteen years, to have shared his friendship until the time of his death, more than fourteen years later, has been one of the privileges of my life.

How well I remember the moment when first I saw him, the figure which in later years became so familiar. It was in Berlin, nearly thirty-nine years ago, at the ninth International Medical Congress. We were standing near the entrance to one of the halls in which the Congress was in session. Among the throng of members passing to and fro, my eyes were attracted by a figure which stood out from the rest. Why?

I was often asked myself. It is not easy to answer. Why, in our early memories, do certain vignettes of face, figure or scene, remain clear and sharp against the haze of the vanishing background?

It may have been the name that was already his. It may have been that my association with him began so soon afterward. Be that as it may, it is the one figure that remains in my memory. My companion I have quite forgotten. Indistinctly I see the building. It was, I think, a temporary, wooden erection. Vaguely I see men wandering about or chatting in small groups waiting for the hour of reassembly; it must have been at the end of the midday recess. But as clearly as if it were before my eyes, one figure stands out—the figure of a man who was not wandering about, who was not idly conversing. Alone, seemingly oblivious of those about him, with an easy, elastic, swinging stride, rapidly but without haste, his open frock coat flowing in the breeze, a package of papers in his left hand, he passed by and entered the hall. He was not a large man. Rather spare but well built, he gave one the impression of vigour and energy. He wore a silk hat and carried a stick. He was obviously well dressed. Among the idle groups, talking together, observing and commenting on their neighbours, he passed, a figure apart, plunged in his own thoughts. The oval, dark, almost olive face, with the long, drooping, black moustache, was calm and composed, and the deep, thoughtful, dark eyes betrayed the serene, intent and active mind.

"Do you know who that is?" said my companion, who had followed my gaze. "That is Osler, professor of medicine at Johns Hopkins."

How much of Osler there was in that first gimpse! Of how little was I conscious at the moment! How little did I fancy that in three months I should be sitting at his table, and that to him I should owe so large a part of the blessings of my life!

In less than three months the occasion came. One evening, after dinner, I was sitting alone in the little room which, for three weeks in Boston, had served me at once as study, consulting

* Thayer—California and Western Medicine.

room, and bedroom. The door bell rang and my friend C entered. He had come to say "Good bye.' He had just finished his interneship at the Massachusetts General Hospital, and was on his way to Europe to spend a few years in special study. At the doorway on leaving, as an afterthought, he asked me if I knew a young man who had had an interneship, who might care to take a position in Osler's new clinic. It was not an important position, but it offered opportunities for study, and a residency, with the privilege of being one of Osler's staff.

In a few days my old comrade Finney, who had already been in Baltimore a little over a year, and I were supping with Osler and his niece. How well I remember him as he was in those days, the same figure that I had seen in Berlin—the "Chief" as we all called him—lithe, vigorous, handsome. The eyes I remember most clearly; deep, dark, rich, brown eyes; at rest grave, even sad; sometimes, when he looked up suddenly from his work in a moment of deep thought, almost severe. The genius of Sargent caught such a moment in his well-known crayon, a passing expression familiar only to those who knew Osler best. Severe at such moments, grave and inscrutable when at rest, they were warm and glowing and kindly and direct as they met one's glance and singularly mobile, in a flash sparkling and dancing with merriment as he seized with lightning rapidity the humorous aspects of the situation, and broke into a quick, nervous or more rarely, when taken off his guard, into a loud, short, hearty laugh. His glance never evaded another's. Steady, penetrating, his eyes looked deeply into your own. Indeed, as was said amusingly and epigrammatically, by Julia Arthur, of the eyes of his favorite pupil, John Hewetson, eyes that were not unlike his own. "They looked through you and buttoned behind!"

His manner of speaking was charming. His voice was quiet and even, but rich and sympathetic. His movements were easy and measured; his gait, rather rapid with long, swinging strides. His composure and poise were unusual. He practised himself a virtue which he often praised, the "virtue of taciturnity." But he was a good listener and had an unusual skill in guiding a conversation. If the conversation took a turn of which he disapproved, he could cut it short or change the subject with ease

I had been told that he had a rather quick temper. This may have been true, but not in the ordinary sense of the word. In the fifteen years during which I saw him nearly every day, I never heard him speak a hasty or an ill-considered word. On very few occasions, three or four only, have I heard him speak severely or sharply. Once, when a silly woman talked to him about his eyes, he seemed to lose his temper and said: "Woman, don't you dare to talk to me like that." His self-control was perfect. Better I think than anyone that I have known, he practised what he preached.

When in thought he had a habit of holding his head a little on one side and stroking his moustache which, in his earlier Baltimore days, was long and drooping. He had a quick wit and a delightful sense of humour. Especially sensible to the incidents of human behaviour, his eye missed little of that which went on about him. When, one hundred years after his death, the little silver-clasped volume in which he set down early incidents in the history of the Johns Hopkins Hospital is opened, there will be revealed, I fear, with that humorous exaggeration with which he loved to embellish these little histories, more than one incident which might embarrass some good citizens of yesterday and today. We who were his assistants

had an uncanny sense of mental and moral nakedness in his presence. How we should like to see those pages and to laugh or blush at ourselves as we appeared to others. One day he read us what purported to be an extract from this volume, describing the effect of the appearance of Miss Isabelle Hampton as an applicant for the position of Superintendent of nurses on the original board of trustees, a group of more than mature and serious-minded worthies. A killingly funny picture it was. Miss Hampton was a pleasing object, and the behaviour and instant capitulation of the board was told in a fashion that will make some of its members turn in their graves.

To this sensitiveness to the amusing incidents of human behaviour was allied Osler's love of all manner of little practical jokes and mystifications of which so many have been told. For this, at the outset, most of us were unprepared. But we learned soon!

Sometimes, alas, there was method in his innocent appeal to our memory. "Oh yes. Of course, you remember that lovely thing in Walters' Gallery, over the door in such and such a room, etc., etc. . . ." Woe to the wretched youth whose embarrassment tempted him to acknowldge a spurious recollection! At the first hesitation he was trapped and exposed.

One cannot think of Osler without the thought of incident after indident of that playful bantering with friends with which his life was filled. Cushing has recorded many.

One day, soon after arriving in Baltimore, he dropped in to see his distinguished colleague X, like himself a bachelor. When the excellent hostess, who looked up to X as did all, with unbounded respect. said that he was not home, Osler asked for "Mrs. X and the children." Before the amazed lady had an opportunity to explain, he apologized profusely and, in feigned confusion, hurried away.

That enigmatic character Dr. Egerton Y. Davis of Caughnawauga dogged his path. After the morning session of a medical congress in Washington in 1893, as we were on our way to luncheon, a stranger greeted him as "Doctor Osler," but, struck by his blank expression, hesitated and said: "This is Doctor Osler, is it not?" "No," replied Osler, "this is Doctor Davis." The stranger was surprised, would have sworn that he had heard him speak but a few minutes before, apologized and passed on. A half hour later at our table at the Arlington, the same man stopped to speak to Jacobi, greeting "the Chief" as "Doctor Davis" Jacobi cast a sly glance at me, and Osler's eyes twinkled.

During his Philadelphia days a patient had been sent to him from Canada, an exceedingly attractive and highly neurotic woman, who was transferred to his friend Doctor S. for a rest cure. At the consultation, as in the presence of S., he said good-by to this patient, she suddenly threw her arms around his neck and kissed him. He escaped and went, immediately, to the Philadelphia Club, where, to a group of friends, he told the whole story—*about* S. Later in the day when S. sought to tell the true story about Osler, he was greeted with derision.

He was the despair of reporters. On one occasion when Doctor Jacobi of New York was to give a lecture in Baltimore, and a reporter asked him for information, he described the tiny little man with his leonine head of gray hair as a "great athlete."

On another occasion at a meeting of the Association of American Physicians a reporter came up to the group where he was sitting, and asked if anyone

could give him information about the celebrities present. Pointing to Delafield with his long square-cut beard and serious face, Osler told the reporter his distinctions, and added that one of the most remarkable things about him was that he was an enthusiastic ball player; that it was almost a mania with him; that, even then, he could not see boys playing ball on the streets of New York without rushing out of his house and joining in the game.

And again, there was the patient sent to Doctor M. of Asheville, brilliant, active, enthusiastic, with the explanation that Doctor M. was a charming man, able and learned and particularly kindly, but very difficult and rather taciturn; at first, the patient might find him a little difficult to approach. Several days later a special delivery letter arrived from the patient saying that Dr. M. had been all that he had been prepared to expect in sympathy and kindliness, but he feared there must have been some serious mistake, for he said: "*This* Doctor M. began to talk so soon as I arrived, and he hasn't stopped yet."

Dear E., the purveyor of the hospital, knew and appreciated the possibilities of the Baltimore markets better than any us. Living alone in an apartment of two rooms in the hospital, he chose his friends with care and discrimination, and gave them, from time to time, dinners that we are not likely to forget. The "Chief" used to love to talk to him seriously of the unquestionable pathological influence of certain favourite Maryland dishes—of the indubitable relation between crabs and cancer, oysters and arteriosclerosis, terrapin and impotence; and E. later, with laughter which ill concealed a slight reserve of mental perturbation, would say: "There's nothing in that, of course, is there?"

One evening Futcher saw the Chief in a sharp attack of renal colic which, as he used to relate most entertainingly had begun just as he was reading a paper of Ebstein's on the passage of round worms marked by bands caused by spasm of the *Ductus communis choledochus*. On the following morning, in the urine, which had been saved and sent to Futcher's consulting room, was a small, stone a tiny, round, white pebble, which he had picked up in the garden and dropped into the specimen before its delivery.

The Chief's visits were made at nine o'clock—at exactly nine—for he was never late at an engagement. At about five minutes before nine he arrived at the entrance of the hospital and, leaving his hat and stick in an anteroom, stepped into the superintendent's office for a word of greeting, and then to the wards, often stopping on the way to wave his hand to the superintendent of nurses as he passed the door.

For the first seven years there were no undergraduate students in the wards. The visits, however, were always followed by a group of postgraduate students, among whom were men who have since become leading figures in the medical profession. As he entered the ward, followed by the little group which had gathered about him, Osler accosted the nurses usually with some facetious or pleasantly bantering observation, and as he approached the first bed, it was generally in an atmosphere of pleased smiles if not, indeed, of frank laughter.

At the bedside the house officer read the history of the new cases. Usually before this was begun, the confidence and sympathy of the patient had been gained by some odd, quaint, kindly remark. The history read, the Chief examined the patient, always objectively, never demanding information from the laboratory until he had first formed his own impression.

If it were a question of an examination of the blood, he always took a glance at the fresh blood himself. He dictated a note as he went along and with great discretion, sometimes briefly, sometimes at considerable length. The simplicity of his teaching was very striking. He never lectured. He discussed the picture informally with those about him, often appealing to their opinion. It was easy, as he talked, to see that that of which he spoke was the result of wide and well-digested experience. His interpretation of physical signs was based on his own anatomical and pathological observation and physiological knowledge. Always, when possible, he followed his patient to operating room or necropsy table where, again, his experience was clearly apparent.

In that, the second year of the hospital, his consulting practice was not very absorbing and he was much at the hospital; nearly every day. After an hour or two in the wards he paid a short visit to the several private patients, and then passed to the out-patient department, where he walked from room to room, examining and commenting on the interesting cases. These visits also were followed by some of the post-graduate group.

At twelve o'clock on Saturday he gave a public clinic in the amphitheatre, where one or two patients, brought from wards or out patient department, were presented. At these clinics, again the Chief spoke with informality and simplicity. There was no attempt at oratorial effect. So entirely informal and simple, indeed almost conversational, was his manner, that, in the beginning, those who had expected to hear finished, rounded, carefully prepared clinical lectures were almost disappointed, and rather puzzled at the reputation Osler had acquired in his five years at Philadelphia.

One day during the early weeks of my Baltimore experience, as we were walking "down town," a distinguished colleague of Osler's in another branch of medical work said to me: "This man Osler. What do you think of him? Do you not think he is an overestimated man?" I agreed that I was surprised at the informality in all senses, of the one or two public clinics that I had heard, and that I was a little puzzled at his great reputation as a teacher; but I told my friend that I was struck by the way in which, at the bedside, he went to the core of things, and that I could not help feeling that he was a remarkably wise clinician. I wonder if my dear old friend remembers that conversation? It was not long before we were one in our feelings about Osler.

Week by week, these simply conducted clinics impressed his auditors more and more. Smoothly prepared exercises they were not. They were far better. In the informal comments of the teacher, in his dialogue with patient, student, and house officer, there was always meat, and his short, quick, spontaneous, epigrammatic comments were sometimes dramatic. Five years later he began what were, I think, the most characteristic and delightful of his hospital or university exercises, namely, the twelve o'clock clinics given in the out-patient department. These clinics were for third-year students and were supposed to be purely diagnostic. One or two patients, of whom Osler knew nothing, were set apart from those who came to the out-patient department that morning in order to be brought before the Chief. The history was briefly presented, and very often largely elicited by the Chief himself, who examined the patient before the class. These were beautiful demonstrations of how to approach a patient, personally and medically. In the course of time these exercises were often used by outside physicians who

brought interesting patients unable to meet the expense of a formal consultation. The delightful personal relations between the Chief and the individual, his quick apprehension of the kernel of the situation, the regular manner in which he proceed from history to examination, to the discriminating consultation of such further investigations as were necessary, was of invaluable assistance to the students.

Especially striking was Osler's historical interest and knowledge. He was not one who loved to roll under his tongue some meaningless name in connection with a symptom, but he used to refer us to the original description of many pathological processes or methods of clinical investgation with which we were concerned in such manner as to excite our interest in the man and his work. In later years, at the twelve o'clock clinics, he frequently asked the student whom he had called up in connection with the examination of the case, to report a week later, in a brief five-minute paper, on the history of some symptom or clinical phenomenon, referring him to the original bock or article. In this way he taught his class far more about the history of medicine than they would have learned from a dry, systematic course of lectures.

At the hospital historical society, which met once a month, he used to request his assistants to read short papers on this or the other distinguished figure in medicine, papers which he discussed always in a fascinating manner, illustrating them commonly with original editions of the works of the individual under discussion. My first real acquaintance with Lænnec and Bichat I owe to just such tasks as this set me by the Chief. Interest once awakened was generously rewarded. My little paper on Lænnec brought me, as gifts from the Chief, the first four editions of the works of the master.

The first and third Monday evenings of the month were given to medical meetings held, in the early years, in the north-east corner room on the ground floor of the main building and, later, in the amphitheatre. The second Monday in the month was given to the historical club. Informal gatherings about the table in the old library, they were attended by most of the staff. Interesting cases from the wards were presented and discussed, and the progress of work in the pathological and bacteriological laboratories was reported Welch and Osler always came; often Halsted and Kelly, and sometimes Newell Martin from the physiological laboratory across town.

The medical school had not yet opened, the laboratories were few, and the gatherings were small and intimate. How delightful were those evenings ! Occasionally outsiders reported their observations. Some who can look back to those days will remember an amusing occasion in which the Chief's humour and tact were particularly well illustrated. Dear old Doctor V. appeared that evening with a large package done up in newspapers. Doctor V. was a charming old man chiefly famed for his rippling laugh, and for having read at an important public meeting a paper in which he had referred repeatedly to "the malarial orgasm." He desired on this occasion, he said, to speak to us of an interesting instance of habitual abortion at about the third or fourth month with regard to the cause of which he had been in doubt. The woman, if I remember, had aborted three times. He had suspected syphilis, but the fœtuses, he said quaintly, "were perfectly formed, without spots or eruption." He did not mention the placentae. Finally, in the patient' stools, he had found "the proglottide

of a tapeworm." He described minutely the preparation and treatment of the patient while unrolling from their abundant covering of newspapers two large preserve jars and, as he poured the specimens into two tin basins, he concluded with the words: "......and at 12-15 noon, she passed this worm," adding plaintively: "I couldn't find the head."

He then raised the question as to whether the worm might not have been the cause of the abortions. The audience had a hard time but behaved with reasonable dignity. When the proper moment came, the Chief, with a quiet twinkle in his eye, stroking his moustache, expressed his interest in the story but said that he could but remember having heard old Sigmund in Wien say that syphilis was the snake that lay at the root of all evil. "I am rather inclined, Doctor V.," said he, "to think that, in this instance, it was, after all, the other worm." The old man chuckled and shook, and the audience gave full vent to its pent-up amusement.

Ah, those library meetings! Few who remember them can think of them without a tender regret. We were all young then, "Popsy," the "Chief," the "Professor," Doctor Kelly, "Counc," Abbott, Nuttall, and all the rest. All were keenly interested in everything, and each in something in particular. It seemed to us then that there never was such a group.

The Chief was charmingly cordial with his staff. Often he invited one or another to dinner; and at midday dinner and supper on Sunday evening, there were always several of the boys. At first he was at the hospital daily, but outside of the hours in ward or outpatient department, and those meals to which the boys were so happy as to be invited, we rarely saw him. To no one alone did he give much time.

One day Lafleur, speaking of him with the affection that all felt, said: "........but he is the most impossible man! I never get a chance to speak with him. Weeks often go by without my having an opportunity to talk with him!"

This was very true, as I came to know before long. Osler knew how to conserve his time. In the fall of 1890, when I arrived in Baltimore, he had already begun his book on the "Practice of Medicine," a work the value of which depended largely on the circumstance that it was the production in great part of personal experience. He had lived for fifteen years by bedside and in laboratory. He had devoted himself single-heartedly to the study of physiology and pathology in its broadest sense. He had himself seen, during life and after death, most of that of which he wrote.

These two years, from 1890 to 1892, were happy moments for such work. His consulting practice was not yet large. In the summer of 1890, when his niece had become engaged to be married, Osler gave up his house and, during the school year, 1891-1892, he lived with us in the hospital, and devoted almost his whole time to the wards, to teaching, and to his book. That was a delightful year for us who were then internes and assistants living in the hospital. His capacity for concentrated work was remarkable. The greater part of his book was written during that year. As I look back it seems to me that his only moments of repose must have been an occasional evening snatched from the usual routine, and a half hour before bedtime which he generally spent in Councilman's room in conversation which was rarely serious, and always delightful.

One evening he had been to the theatre to see Richard Mansfield in "A

Parisian Romance." After a few bantering words with Councilman he said, as he left the room, " Oh, by the way, there were two deaths to-day." " Ah," said Councilman, " what were they ? " " Both," replied Osler, " were instance of arteriosclerosis; one, an hemiplegia." " Are there to the autopsies ?" said Councilman. "Yes." " At what time shall I do them ? Will ten o'clock do?" " Yes, that will do." As we walked down the corridor Osler chuckled. At ten o'clock on the following morning Councilman came to the ward to remind us of the necropsies that he was about to do on the two fatalities in " A Parisian Romance."

One could not live with Osler without being captivated by his personal charm, his extraordinarily quick wit, without being impressed by his learning and his wide general information. He had a remarkable memory. Never have I known one who could read a scientific article so quickly and detect and remember its essentials so surely and so accurately. But he was not so accurate or systematic in recording his references, and some of us can remember hunting long for this article which had appeared in that journal at such and such a date. The memory as to the article and the author were almost always correct. The journal and the date—that was another matter.

He refused flatly to waste time in futile controversy and discussion, and it was hard, if not impossible, to persuade him to enter into any controversy with nurse or superintendent. There were abuses which he preferred to endure rather than risk unpleasant discussion, and, as Smith has said, on one occasion, in connection with a situation which seemed to us rather dangerous, he advised capitulation because of the threats of the "nursing authorities." But he did it skillfully, and within a year the suggestions which had been objected to were proposed spontaneously by those who had been objectors. As he capitulated he said to me : " I long ago made up my mind that the only way to deal with a woman is never to take her seriously." This procedure was with him an art, restricted in its application to neither sex nor age. If he refused to take you seriously, you were helpless and, vexed though you might be, you could not lose your temper with him.

Throughout his life he was master of his own time to a remarkable extent. I know not how he did it. He seemed to be able to slip away when he would and one could not talk to him of that which he would not hear. Not even his assistant could catch his ear. In his moments of leisure, at meal times on his way to and from the wards or when talking to private patients, he was always gay and amusing, but neither patient nor friend nor stranger could hold him if he were busy. How he escaped them I could never quite discover. It was almost always through some quiet, amusing, diverting remark which caused a laugh or suddenly changed the subject. And in a second he was gone.

His visits in the private ward were delightful, a round of laughter and gaiety. In one room our poor, old, arthritic friend, Mr. D., who suffered through so many months, was always, through some new bit of nonsense, reduced to laughter until he cried from some twinge of pain caused by the physical activity provoked. And here it was the charming but very loquacious nurse with brittle bones, who suffered, on several occasions, fractures of rib or arm or leg, who was always greeted by a solicitous inquiry about her jaw. Or again the sad-faced hypochondriac with a treasured store of questions, who was greeted by some salutation so surprising that his train of thought was exploded as by a mine. Or the anxious psychasthenic, who was

so quickly engaged in a playful discussion of the colour of the ribbons on her nightgown that she quite forgot the number of hours that she had or had not slept—and always he was gone. How? Where? No one wholly knew.

All the while, on the basis of good anatomy and physiology and pathology he was showing us boys as he was showing his students later, that he was a masterly diagnostician and, on broader lines a very wise doctor.

There were those who called him a "therapeutic nihilst" and complained bitterly that he paid little attention to the treatment of the patient. It is true that in his ward teaching, as in the private ward, he did not dwell particularly on certain lesser details of treatment which are often important in daily practice. This part of the instruction he delegated to others. In the private ward he always left these duties to his assistant, saying that he wished to be considered as a consultant. But in relation to special conditions which he was studying, such as malarial fever, amœbic dysentery and and typhoid fever, he went into the treatment with care. If however, he did not in his teaching give time to the discussion of the details of medication, to the character or the colour or the taste of the menstrum in which the drug might be administered, he did, through his daily intercourse with patients, public or private, teach us how to conduct ourselves with the patient and how to practise medicine. This was quite in character with the conduct of his life. He taught by example, not by precept. He taught us very quickly that medicine could not be practised and that disease could not be treated by rule of rote. He taught us that the treatment of the patient was the most important element in the treatment of disease, that the patient not the disease was the entity. He taught his students to use their minds and stand on their own feet. He taught us not to give medicine unless we had a real reason for it. How often have I heard him say that if one wanted to find a disease for which there was no known treatment of special value, we had but to look at the index in a book on therapeutics for the longest list of recommended therapeutic agents.

His therapeutic influence was very wise. He was not interested in the reckless use of newly introduced preparations, and he was always insistent on the careful and intelligent use of those which were tried. His recognition of the importance of rest as an adjuvant to *vis medicatrix naturæ*, and his clear demonstration that the efficacious dose of a specific, as of quinine in malaria may be materially reduced if the patient be given that rest and general treatment which is desirable, was an important contribution, which is not observed sufficiently in general practice. Many physicians in those days, as today, felt a curious sort of obligation to give the patient medicine. Osler taught his students very clearly the irrationality of this old tradition. He taught us to feel the obligation to be honest with our patients, and especially to avoid doing anything meddlesome or harmful.

At the end of his year in the hospital in 1892, and the completion of the book, Osler was married, and that beautiful, happy, fruitful life at 1, West Frankin Street began. Mrs. Osler who as I have said, was his perfect complement, brought with her Morris, the melanotic butler, a personage of great affability, discretion and respectability, who guarded the Chief with rare skill. Almost immediately the house became the home and the haven of assistants, house officers, and visiting physicians from all parts of the world. The Chief, as I have said, practised what he preached, and his

life was remarkably regular. Breakfast a little before eight; to the hospital at nine, three days in the week. On the other days the mornings were spent in work at home. A cold luncheon at quarter past one, followed by twenty minutes to half an hour's sleep or rest. Consultations at home from two to five. Outside consultations, thereafter. Dinner at seven. At half-past four tea, over which Mrs. Osler graciously presided. Some of those who gathered at afternoon tea were always waiting for a coveted minute with the Chief, which was realized only if he had no outside consultations. More commonly he dropped into the drawing room for a few minutes, talking pleasantly with the group before he left for the few outside consultations before dinner. In the evening he did no set work.

In later years we, who had keys to his house, rarely interrupted these evening hours. When we did run in for a few minutes, Mrs. Osler was generally sitting before the fire and the Chief at his desk, signing the letters of the day, or writing short notes or reading. There was no telephone in his house. Those who desired to make appointments could write or telegraph. This spared him much. He was usually in bed by half-past ten. This was true whether the evening had been spent at home or dining at some medical gathering, for he rarely dined out in society. Wherever he was, he generally disappeared at about ten o'clock.

His life was a rare example of temperance in all things. He smoke without inhaling, I think, two or three cigarettes after luncheon and dinner. He ate sparingly. There was always wine on his table, usually a decanter of sherry, sometimes red or white wine but he never drank more than his glass of sherry or at a large dinner, an occasional sip of wine in addition. Vigorous and naturally athletic, he realized that he who is doing heavy mental work should not burn the candle at both ends. One morning when he was in his fifty-first year, the picture of health and vigour, we came, on the golf course, to a little stream, not more than three feet wide. He started to jump it. Then, reflecting for a second, he stopped and turned to the bridge, saying: "No, I made up my mind that at fifty I would stop jumping streams." The memory of his tolerance and moderation shines in these days of fanatical and self-righteous intemperance.

Nothing could have been more charming than Osler's relation to under-graduate student. Every Saturday evening the group doing their ward work in medicine gathered at his house. Assembling about the dining table, they discussed the interesting cases in the wards, over beer and sandwiches, while the Chief talked informally of medicine, of men, of books, of history. His talks were illustrated often by the demonstration of treasures from the library which developed into that great collection which surrounds his ashes at Montreal. At these meetings the students came to know the man and to feel his full charm.

In after years Barker and Janeway and I carried on these same evening gatherings. At one of these, as I spoke to the group of Osler, and happened to say that I had never heard him say an unkind word of a colleague behind his back, and more than this, that he never allowed an unkind word to be spoken in his presence, a graduate of some ten years' standing who was visiting me, said: "I know that to be true. One night Doctor —— of ——, an old assistant of the Chief's at McGill, was with us at a Saturday evening meeting. He started to remind Doctor Osler about some rather absurd incident at the expense

of a colleague, when the Chief abruptly turned and, pointing to the picture behind his back, said: 'Do you not think that statue of King Arthur in the church at Innsbrück is remarkably fine?' The old colleague stopped, flushed, and embarrassed, while Doctor Osler quickly started another subject." This was a characteristic incident. Osler taught his students that only he whose tongue was guiltless of criticism could be the friend of every man. The severest word he ever spoke of another was laughingly to refer to him as a "Son of Belial."

But now and then, in the garb of the jester, he told the truth in an unexpected fashion. One evening X. knocked at the door of Y.'s room, where the Chief was sitting. X. was not welcome, a truth of which he had no conception.

Y. groaned and, uttering under his breath some highly uncomplimentary remarks, shouted: "Come in!" "Mercy, X.," said the Chief, "you'd not have come in had you heard what Y. just said about you!"—a remark which confounded Y. but amused the unsuspecting X.

On another occasion a notorious charlatan within the profession, Doctor T. of C., brought me a sealed letter of introduction presenting "Doctor Schunck."

He respected his colleagues. He loved his fellow men. He saw the best in them, and in his presence the best in them always came out. He recognized and by his actions taught us the dignity of medicine as a profession. Sordid discussions as to fees or as to the financial side of practice were particularly unpleasant to him. I am sure that he never speculated on a patient in his life. He knew the honorarium that he expected for a certain service. Naturally, as he grew older and the demands on his time increased, his charges were higher, but he never raised his fee to a richman simply because he was a rich man. He had a horror of the commercialization of medicine. Fee tables, especially, were anathema to him.

He was one of those rare practitioners of medicine who could easily have made a fortune. His professorship brought many obligations in the entertainment of visitors of all sorts. These he met with charming generosity. After fifteen years he took from Baltimore not a cent more than he brought with him save, the income from his book. He loved his profession: he was jealous of its reputation. To think of medicine as a mere trade would have disgusted him.

As the years went by he became an exceedingly busy man. With all his skill in controlling his time the moment arrived, as he, once wrote me, when he could no longer have stayed in Baltimore "above ground." And so he went to Oxford.

Some of us who had lived with him day in and day out had always realized that he must one day return to the "old home," which was always the home of his spirit. We loved him dearly. He had become a part of our life, but few of us. I think, were prepared for the shock that the news of his impending departure gave us. It brought an unexpected sense of personal loss and sorrow, leaving with us something of that strange sensation of age and loneliness and responsibility which comes with the loss of a parent. He had grown into our lives to an extent that we had not realized. How deep this feeling was, was shown by the remarkable spontaneous gathering of his old students which greeted his first visit to Baltimore.

In Oxford, Osler's days were spent in a congenial atmosphere of scholar-

ship among students and books. They were still very active days. His quickening spirit surrounded him with new life wherever he went. Cushing has told us of his open house. I say " his " perhaps I should have said " theirs. " From the day of his wedding one could hardly think of Sir William and Lady Osler apart. Revere, the only child, grew to be a charming, promising figure.

The war came out of a clear sky. To Osler, whose international associations were so wide, this was a heavy blow. To this was added the cruel anxiety about his son ; and then the crowning tragedy of his death. All this and the broken heart he bore with a high head, and she by his side. With death in their heart, life went on as before. The house remained open to all.

A year later, just after the Armistice, I saw him for the first time in four or five years. It was a shock. Affectionate and cordial as ever, older, his moustache white, there was a quiet, subdued look in his eyes when at rest that was not his, a look that haunted me : . . ."He looks small and although charming and like himself at moments, he has lost the real, sustained snap. He looks small and—how shall, I say it—almost like any other nice old man. " These words, which I find in my " Notes by the Way, " tell a story. The Chief to us was unlike anyone else. To think that he could look like onyone else seemed almost sacrilegious.

But life went on as before. He was among the first to stretch forth his hand to greet and help those who had suffered, without regard to the memories. A physician, he was elected president of the Classical Association. Spring brought new life, and in his beautiful address. " The Old Humanities and the New Science," there was all the ring of the " Chief " of our memory.

In the summer came his seventieth birthday and the July fasciculus of the hospital bulletin, which gave him some conception of what he meant to his friends and students, and made him very happy.

In the fall came the railway strike, and the long, cold journey, home from Newcastle, and the empyema. With December and winter came the end.

And then, the nine years of work by his dear cousin, Francis, on " Bibliotheca Osleriana, " the great catalogue of his library. And the same open house and the same joyous gatherings of students and disciples, young and old, and Lady Osler as gracious and bright and lovely as ever. The same dear, familiar fireside that was home to so many.

Finally the catalogue was done. The packing cases stood waiting. The morning arrived on which the books which held so much of his heart were to be taken from their shelves and put away for their long journey.

Then, when all was ready, peacefully, Lady Osler left a lonely world, and joined the Chief in the cradle of our loving memories. It was as if his spirit had lingered in her until the work was done.

ASSOCIATIONS.

Mr. G. S. Bajpai's statement that one of the reasons why Licentiates have been kept out of the scope of the Medical Council Bill was that the majority of Local Governments were opposed to such a step, is hardly surprising. The question is, however, whether in a matter of this kind, where the interests of thousands of medical practitioners are involved, it is equitable or just to follow the line of least resistance. Local Governments have, perhaps, been influenced in this

matter by the views of the leading members of the profession of medicine who own allegiance to the General Medical Council of Great Britain. In any case, the members of the Central Legislature should review the whole question and if they find that, in the present circumstances, it is not possible to do justice to the claims of Licentiates, they should demand a postponement of the measure, a step which for other reasons also, appears to be called for.—*Hindu, Madras.*

Indian Medical Association.

The following is the text of the memorandum submitted by the Indian Medical Association, on the proposed Indian Medical Council Bill, to the Government of India :—

This Bill to establish a Medical Council in India is the outcome of a great deal of discussion and agitation in the past. It was brought to a head by the decision of the British General Medical Council to withdraw their recognition of Indian medical degrees, in consequence of which a Conference of Provincial representatives was held in Bombay in 1930, which, after condemning the action of the General Medical Council decided that we should set about putting our own house in order. It was felt that, with a view to establishing a uniform minimum standard of medical education in India, it was necessary to form an Indian Medical Council. It is necessary to recall these facts because to no small extent has the attitude of the General Medical Council governed the provisions of this Bill. A reference to the covering letter of Mr Reid makes it clear that one of the reasons for the introduction of this Bill is to safeguard the "international status of Indian medical degrees which has been endangered by the action of the General Medical Council."

"To a Large Extent Premature."

Before proceeding to a consideration of the merits of the Bill, it is necessary at the outset to view the measure in the light of present and impending circumstances. The provinces of India have reached different stages of development from the point of view of provision of medical education, relief and prevention of diseases. It is difficult to foresee what attitude the provinces will take and what would be the position of an All-India Medical Council, under the new constitution. Under the Federal Governments of both Australia and Canada each constituent province regulates its own medical policy and it is not unlikely that the same attitude would be adopted by the provinces in India under the Federal Government. The position of the Indian States must also be taken into consideration. In these circumstances, therefore, the Bill is to a large extent premature. It would be futile to make an enactment which would, at no distant date, have to be entirely overhauled This fact needs to be kept prominently in mind and if, in spite of this fact, Government persist in introducing the Bill, then it ought to be framed as far as possible in the light of what control and powers the impending constitutional reforms would give to the provinces.

At this juncture, however, we should remark that in a measure so far reaching in its effects and which has a technical and special aspect, namely, the interest of the medical profession in India, the Assembly should have the advantage of expert opinion on the subject—opinion that has the confidence of the great body of the medical profession whose interests are concerned. We, therefore, submit that to the Select Committee should be nominated a competent member of the independent Indian medical profession and one who

has the confidence of the profession to represent their views.

If we are to have an All-India Medical Council it is advisable that this Council should be comprehensive and not restrictive in its scope. The preamble however limits the Bill to a very narrow channel, namely, the maintenance of registration of the "higher" grade of the qualified practitioners in order to establish a uniform minimum standard of "higher" qualifications in medicine for all provinces. The qualification "higher" is not only vague but such a qualification was not contemplated either in the previous draft Bill or at the Inter-Universities Conference. Thereby the largest section of Indian medical practitioners (about 30,000 in number) is excluded. Furthermore, the Bill offers little or no incentive for doctors to place their names on the proposed All-India Medical Register. Unlike other countries in which privileges and immunities are allowed to medical men, this Bill entirely omits reference to them and gives nothing in return except perhaps a vague and problematical prestige, for a not inconsiderable registration fee. It gives nothing more than what registration under the existing provincial Councils of Medical Registration now provides. There being a reciprocal relationship between the various provinces, a practitioner now registered in any one pronvince is free to practise in any other province.

Apart from the scope of the Bill, we would ask what is the real purpose of the measure. If it is to place our own house in order, to improve the standards of medical education in India and to conduct our medical policy in a satisfactory manner, the intention is laudatory and not one at which we would cavil; but if the intention is to effect any of these things merely in order to placate the British General Medical Council then we would point out that there is much ground for objection, quite apart from any question of sentiment. Unfortunately, the Government's action and statements lead us to infer that the real intention is to placate the General Medical Council and we should be at some pains to point out how unnecessary this is. In the first place, we can put our own house in order quite independently of the General Medical Council. In the second place, we have to study the interests of the overwhelming number of practitioners in India before the interests of the few scores of men who proceed abroad for medical training, particularly to the United Kingdom. In the third place, those who proceed to the United Kingdom in order to graduate find no difficulty within a short time of arrival in qualifying under the Conjoint Boards in England and thereby obtaining recognition by the General Medical Council. Lastly, it might be remarked that an increasing number of Indian students are proceeding to Continental countries where they are given every encouragement and facility and are even provided with scholarships. The language difficulty is overcome by the fact that lectures, as in Vienna, are delivered in several languages, and in fact some of them have adopted English as the medium of instruction. If, also, it is thought that to bring the licentiates within the scope of the Bill would jeopardise the chances of recognition of Indian medical degrees by the General Medical Council, we submit that the interests of these 30,000 medical practitioners are more important than the regaining of recognition by this British Institution.

All these facts have to do with the question of reciprocity and we would consider it an insult to the dignity of this country if, in the consideration of reciprocity, the Indian Medical Council occupied an inferior or subordinate status to that of any foreign medical

body. For this reason we assert that, as a matter of principle, it is for the Council upon formation to negotiate reciprocal relationship and it is a negation of this principle to give British medical degrees automatic recognition such as is attempted in the Second Schedule of this Bill. This principle would be present even if the British General Medical Council had not withdrawn its recognition of Indian medical degrees, but the fact that it has done so only serves to emphasise the principle.

Apart from these wider issues, the composition of the proposed Council is an important matter. We have remarked above that the spirit of the new Reforms should be maintained and that the Council should be a popular body composed, for the most part, of elected members. For this reason we deprecate the suggested composition which gives an almost preponderating element of official representation. Not only is the President to be nominated, not only are the Local Governments to nominate a member each but also three members are to be nominated by the Governor-General in Council, while even in regard to the members elected by the Medical Faculties it should be remembered that these Faculties have in them a large official element which would ensure the return of an official or one who is officially *persona grata* As against all these, the Provincial Committees are allowed to elect only one representative each and it has to be remembered that in the provinces of Assam and Central Provinces there would be no provincial committee in view of the non-existence of a provincial medical council. The principle of this composition is entirely wrong. The larger interests of the bulk of the medical profession are overlooked while all Government interests are strongly fortified. We do not suggest that both the Central and Provincial Governments are not interested parties, particularly from the financial standpoint; but this in itself is not sufficient reason to give them such overwhelming power as against the weightier interests of the medical profession as a whole. For example, in the British General Medical Council some forty-five of the members are elected to represent the profession and only five are nominated by the Privy Council as representing Government's interests. The same principle is applicable here. If the Provincial Governments are entitled to representation because of their financial interests the Corporations of cities like Calcutta and Bombay might with equal right ask to be represented, for they make large donations to medical education and institutions.

Position of the Licentiates

Lastly, there is the question of the licentiates, who have been trained under the Western system of medicine and are recognised as qualified practitioners in India and to whom we have already referred above. We do not see that the inclusion of the licentiates would, in any way, defeat the objects or purpose of the Bill, in fact their exclusion would place out of the fold the bulk of the medical profession in India which would be a fact to be highly deprecated. We have already dealt with their claim from the point of view of the General Medical Council, though we would add that if a four-year course of medical training in Japan suffices to gain the General Medical Council's recognition there is no reason why Indian licentiates should not be similarly recognised. As a matter of fact Madras has already decided to introduce a five-year course, while the U. P. and Bengal have recommended its adoption. We believe that the inclusion of licentiates in the Central Register would lead to a bettering of their training and status and we do not believe that the medical interest of the

people would be adversely affected by such improvment in their status. The question of fees depends largely on the capacity of the people to pay and the relation between supply and demand of practitioners, with the result no practitioner could put his fees beyond the economic capacity of the people. There would be no greater tendency towards over-crowding in town than is persent to-day. One of the main reason why we object to the exclusion of the licentiates is that it makes an invidious distinction in the ranks of the medical profession in India and also because their exclusion contradicts to no small extent the intention of the Bill to establish a uniform minimum standard of qualification in medicine for all provinces. As we have suggested before, the restriction of uniformity to "higher" qualifications alone is not warranted.

We sincerely hope that the Government will give due and close consideration to the various points we raise. It would be impolitic to force through a measure that has no popular support in which case it would be sure to be altered out of all recognition with the establishment of the more liberal constitution resulting from the Round Table Conference. A statesman-like view is called for and we hope the Government will rise to the occasion.

The Trichinopoly District Medical Association.

A monthly meeting of the above Association was held on Saturday the 18th February at 5 P.M. in the E.R. High School. About 55 doctors were present. Dr. T. K. Manickavasagam Pillay was "at Home" to the members.

After reading of the minutes of the last meeting Dr. T. S. S. Rajan demonstrated two interesting X-ray Photos, one of Exostosis of the vertebrae and another transposition and adhesions of the intestines. Dr. S. Padmanabha Sarma who presided at the earlier part of the meeting introduced the Lecturer Dr. Chockalinga Pillay the Group Leprosy Officer and called upon him to deliver his lecture.

The Lecturer started by saying that leprosy was much more prevalent than the census showed and in his experience he found at least two dozen cases in every village of a 1,000 population. Leprosy was not a hereditary disease. It was communicable in different ways (*i.e.*) direct contact, using clothes, etc. It is a self curable disease, getting spontaneous cure from 6 months to 15 or 20 years. It is predisposed by insanitary living, under-nutrition and excesses, such as alcohol and venereal diseases. He explained the different stages and classification of the disease as A-1 Depigmented Anaes thetic Patches, A-2 Thickned Nervers, A-3 Trophic change (Blisters, Ulcers, Contracted; fingers and wasting Thenar Eminence) B1 Erethematous Patches, B2 Small Nodes with slightly thickened fingers and toes, and B3 with Nodules thickened ear lobes (leonine appearance). He also stressed that bacilli will not be found in A1 and A2 cases but would be found sometimes in nerve roots of A2 cases. Bacilli would be found in the skin in B1 cases and sometimes in nasal smear of B2 cases and in abundance in B3 cases. The new classification according to the latest medical authorities was as nerve and cutaneous leisions (*i.e.*) N1, N2, N3, and C1, C2, C3. Regarding the treatment the Lecturer said that experience showed Chaulmagra oil was the basic principle in the treatment which could be used externally, internally, and by injections, and the most popular and useful form of injection was Hydnocreol. He also advocated the use of Trichlor-Acetic Acid for exter.

nal use on Depigmented Anæsthetic Patches. He also said that regular treatment for 6 months in A cases and for two years in B cases was quite adequate for curing cases of leprosy.

After the conclusion of the lecture there were a number of questions to which the Lecturer replied clearing the doubts. In his concluding remarks Dr. T. S. S. Rajan who presided in the later part of the meeting stressed on the necessity for the early diagnosis of Leprosy and said that the old remedy Chaulmogra still held the field as the specific for the disease. He also warned the practitioners about giving intradermal injections and pushing Potasium Iodide.

With a vote of thanks to the Host. Lecturer, and the President the meeting terminated.

The Fourth Inaugural meeting of the above Association was held at 5 P.M. on Sunday the 22nd January 1933 at the Government Headquarters' Hospital Trichinopoly. About 50 members and two from Chetty Nad Medical Association and Mr. A. V. Raman, Deputy Sanitary Engineer, attended. Dr. L. K. Neelakantan, L.M.S. was "At Home." Dr. S. Padmanabha Sarma, M.B.C.M., President of the Association proposed Dr. T. S. S. Rajan to the chair and Dr. P. A. S. Raghavan seconding it was unanimously carried.

Dr. Rajan, demonstrated the following cases: (1) Excision of the testis and part of the elephantoid skin in a patient on whom he had formerly excised the elephantoid scrotum. (2) An excised jaw which had developed cancer even though the patient was toothless for over six years. (3) An abdominal injury with strangulation of the omentum which he had successfully operated. Dr. Sarma demonstrated (1) a case of excision of stiff elbow which showed remarkable improvements in movements after operation. (2) an amputation of the hand which had become gangrenous due to bad splinting after fracture, (3) and a case of fracture of the hand, a correct diagnosis of which was made by X ray and fracture set in position. Dr M.S.Kuppuswamy Ayyer demonstrated a case of compound fracture.

After demonstration of cases the chairman introduced the lecturer of the evening Dr.A.Srinivasan, M.R.C.P. London as a distinguished scholar just returned from England and called upon him to give his lecture on "Honorary Medical Service."

Dr. A. Srinivasan compared the facility of medical relief obtaining in Great Britain and in India and said that while in the former country there was one medical man for every 1,000, in India there is not even one for every 5,000, of the population. It was to obviate this lack of medical relief that the rural scheme was evolved but the lecturer regretted to note that it was not successful. Introduction of the Honorary Medical System was also in furtherance of this view. He said that there was great drawbacks in the rules and regulations governing the Honorary System as conducted at present which precluded men of high qualifications and attainments from offering Honorary Service.

The Lecturer opined that the control of Honoraries must not be in the hands of individuals but must rest with committees. He pointed out various discrepencies in the rules and he was also not in favour of graded system in the Honorary Service. Dr. S. Padmanabha Sarma while agreeing for the contral of the Honorasies by a Committee said that there must be different grades of Honoraries according to

qualifications and experience of the Honoraries. He pleaded for co-operation of the independent members of the profession. There was a lively discussion in which Drs. Shastry, Sambasivan K. R. N. Chary and Ponnusamy took part. In his concluding remarks Dr. T. S. S. Rajan said that if the Honorary System was worked in the spirit in which it was evolved and was not impeded by irksome rules there would be more eminent members offering their services as honoraries. He also congratulated the junior members of the profession for bringing clinical cases and also for taking part in the discussion.

Dr. P. A. S. Raghavan, the secretary, brought forward a resolution to get the Association registered so that it could be a recognised body and enable the President of Local Bodies and the Government to sanction travelling allowances for members in service.

The Secreatry proposed a vote of thans to the President, Lecturer and the host of the evening. Then the meeting terminated.

Godavari Medical Association.

The first anniversary of the Godavari District Medical, Association was celebrated on the 18th February in the premises of the M. S. N. Charities buildings, Cocanada, under the presidentship of Rao Bahadur Dr. T. S. Tirumurti. 85 members including a number of lady doctors and 23 non-member doctors attended the function. The business meeting commenced at 2 P.M. wherein Major T. S. Shastry, I. M. S., was elected President, and Drs. Audinarayanaswami and Kamaraju Joint Secretaries, and Dr. Miss T. K. Narayanaswami, and Dr. S. Swami Naidu of Rajahmundry and Dr. B. S. S. Prasada Rao of Samalkot as members of the Managing Committee for the new year.

The anniversary meeting was held at 3 P. M. with Rao Bahadur T. S. Tirumurti, in the chair. Dr. Tirumurti, after expressing his great pleasure at such a large number of doctors, delivered an instructive lecture on " Some Recent Advances in our conceptions and diagnosis of diseases." He dealt specially with the subjects of inflammation and repair and œdæma, (inflammatory, cardiac, renal, and other varieties of it).

Major Shastry then spoke about the necessity of conducting a leprosy campaign in the district and exhorted the members of the Association to co-operate in their respective areas when the campaign was organised.

Mrs. J. B. Brown joined in this exhortation for working the leprosy campaign in this district.

With a vote of thanks to the President and the guests of the evening, the meeting terminated.

Guntur District Medical Association.

A meeting of the Guntur Medical association was held last month. The report of the secretaries was read and accepted an all round progress and an increase of membership from 28 to 39 during the year. There was Dr. A. M. Beal, M. D. of the Kugler Hospital, Dr. T. K. Raman, M.D., D.T.M., and Drs. P. Veerayya and C. Hanumantha Rao were elected President, Vice-President and Secretaries respectively for the current year.